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Last Updated: 03/09/2022

Notification of EPSDT Service Authorization Processing Moving to Keystone Peer Review Organization (KePRO) - Effective November 1, 2012

The purpose of this memorandum is to notify providers rendering specific EPSDT services that Keystone Peer Review Organization (KePRO) will receive requests for certain services, effective November 1, 2012.

General Information Regarding Service Authorization

Service authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS member by a DMAS enrolled provider prior to service delivery and reimbursement. Some services do not require authorization and some may begin prior to requesting authorization. Providers are instructed to refer to the appropriate provider manual to determine when service authorization is required for specific procedures and to check the DMAS web portal for the most current fee file. The fee file indicates whether a specific HCPCS/CPT requires service authorization for DMAS covered services. Instructions on how to access the fee file are provided within this memorandum.

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the member's continued Medicaid/FAMIS eligibility, the provider's continued eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual member, a provider, a service code, an established quantity of units, and for specific dates of service.

Retrospective review will be performed when a provider is notified of a member's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain service authorization prior to billing DMAS for these services. Providers must request a service authorization for retrospective review as soon as they are aware of the member's Medicaid eligibility determination.

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EPSDT Services Requiring Service Auth through KePRO

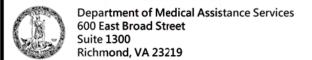
KePRO will begin reviewing requests for the following services, effective November 1, 2012. Any requests received through October 31, 2012 at DMAS' EPSDT Unit will be processed at DMAS. KePRO will receive clinical data on these cases and will honor all final dispositions made by DMAS. For pend responses issued by DMAS through October 31 2012, providers are to respond to DMAS with the necessary information to complete the final disposition.

Documentation submitted to KePRO will be validated within the clinical record upon post payment review. Inconsistencies may be subject to retraction and/or referral to the Medicaid Fraud Control Unit (MFCU) within the Office of Attorney General.

PA Service type (used to request service type)		Procedure Code Definition	Direct Data Entry (DDE) through Secure Web Portal or Fax Form
0092 EPSDT EPSDT AT, Hearing Aids, Chiro, Ortho	V5014 V5030 V5040	Repair/Modification Of Hearing Aid Hearing Aid, Monaural, Body Worn, Air Conduction Hearing Aid, Monaural, Body Worn,	Direct Data Entry through KePRO's Atrezzo Connect OR
	V5050 V5060	Bone Conduction Hearing Aid,	DMAS 363 Outpatient Services Authorization
	V5070 V5080	Monaural, Behind The Ear (Bte) Glasses, Air Conduction Glasses, Bone	Request Form
	V5095 V5100	Conduction Semi-Implantable Middle Ear Hearing Hearing Aid, Bilateral,	
	V5120 V5130	Body Worn Binaural, Body Hearing Aid, Binaural, Ite	

V5140	Hearing Aid, Binaural, Bte
V5150	Binaural, Glasses
V5170	Hearing Aid, Cros, In The Ear
V5180	Hearing Aid, Cros, Behind The Ear
V5210	Hearing Aid, Bicros, In The Ear
V5220	Hearing Aid, Bicros, Behind The Ear
V5242	Hearing Aid, Analog, Monaural, Cic (Completely In The Ear Canal)
V5243	Hearing Aid, Analog, Monaural, Itc (In The Canal)
V5244	Hearing Aid / Digitally Programmable Analog / Monaural / CIC
V5245	Hearing Aid / Digitally Programmable Analog / Monaural / ITC (Canal)
V5246	Hearing Aid / Digitally Programmable Analog / Monaural / ITE (In- the-Ear)
V5247	Hearing Aid / Digitally Programmable Analog / Monaural / BTE (Behind-the-Ear)
V5248	Hearing Aid, Analog, Binaural, Cic
V5249	Hearing Aid, Analog, Binaural, Itc
V5250	Hearing Aid / Digitally Programmable / Analog /Binaural /CIC (Completely in Canal)
V5251	Hearing Aid / Digitally Programmable / Analog /Binaural /ITC (Canal)

	V5252	Hearing Aid / Digitally	
	10202	Programmable /	
		Analog /Binaural	
		/ITE (In-the-Ear)	
	V5253	Hearing Aid / Digitally	
		Programmable /	
		Analog /Binaural	
		/BTE(Behind-the Ear)	
	V5254	Hearing Aid, Digital,	
		Monaural, Cic	
	V5255	Hearing Aid, Digital,	
		Monaural, Itc	
	V5256	Hearing Aid, Digital,	
		Monaural, Ite	
	V5257	Hearing Aid, Digital	
		Monaural Bte	
	V5258	Hearing Aid, Digital,	
		Binaural, Cic	
	V5259	Hearing Aid, Digital,	
		Binaural, Itc	
	V5260	Hearing Aid, Digital,	
	7.750.04	Binaural, Ite	
	V5261	Hearing Aid, Digital,	
	7.750.04	Binaural, Bte	
	V5264	Ear Mold/ Insert, Not	
		Disposable,	
	V5266	Any Type	
	V 3200	Battery For Use In	
	V5267	Hearing Device	
		Hearing Aid Supplies	
	V5273	Assistive Learning	
		Device Cochlear	
	V5274	Implant Type Assistive Learning	
	V 32 /4	Device (FM	
		System)	
	V5298	Hearing Aid, Not	
	V 3230	Otherwise Classifi	
	V5299	Hearing Service,	
		Miscellaneous	
0092 EPSDT	T5999	 	Direct Data Entry
EPSDT			through KePRO's
AT, Hearing			Atrezzo Connect
Aids, Chiro,			
Ortho			
			OR
			D) (4 C C C C
			DMAS 363
			Outpatient
			Services Authorization
			Autnorization Request Form
0090 EPSDT	S9123	EPSDT Skilled Nursing	
Private Duty	00120		through KePRO's
Nursing	S9124	EPSDT Skilled Nursing	
	55121	LPN	
	G0162	EPSDT Congregate	
		Nursing RN	
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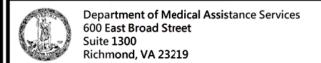
	G0163	EPSDT Congregate Nursing LPN	OR DMAS 98 Community Based Care Waiver Request Form
0091 EPSDT	T1019		Direct Data Entry
Personal Care			through KePRO's
and Attendant		Care Services	Atrezzo Connect
Care	S5126	EPSDT Consumer Directed Personal Care Services	OR
			DMAS 98
			Community Based Care Waiver
			Request Form
0098 EPSDT	S9123	EPSDT Skilled Nursing	
MCO			through KePRO's
Carve Out Svcs	S9124	EPSDT Skilled Nursing LPN	Atrezzo Connect
	G0162	EPSDT Congregate Nursing RN	

G0163	EPSDT Congregate Nursing LPN	OR
		DMAS 98 Community Based Care Waiver Request Form

Methods of Submission to KePRO

All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media type, for service authorization requests submitted to KePRO.

KePRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax and phone. Submitting through DDE puts the request in the worker queue immediately; faxes are entered by the administrative staff in the order received. For direct data entry requests, providers must use Atrezzo Connect Provider Portal. For DDE submissions, service authorization checklists may be accessed on KePRO's website to assist the provider in



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assuring specific information is included with each request. To access Atrezzo Connect on KePRO's website, go to http://dmas.kepro.com.

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on "Register" to be prompted through the registration process. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. The Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the Training tab, then the General tab.

Providers with questions about KePRO's Atrezzo Connect Provider Portal may contact KePRO

by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KePRO at providerissues@kepro.com. KePRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877- OKBYFAX or 1-877-652-9329.

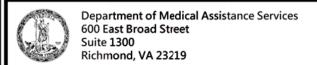
Specific Information for Hearing Aids (Service Type 0092)

Hearing Aid services are only available for Medicaid members under the age of 21 through EPSDT. Only hearing aid providers (provider type 038) and audiologists (provider type 044) may submit hearing aid requests. Providers must submit requests when they are aware of the need for the hearing aid/service and prior to delivery. Providers should expect a response from KePRO within 3 business days of receipt. Hearing Aids are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members.

KePRO will utilize McKesson InterQual® Criteria in making medical necessity determination for hearing aids and related devices. Where McKesson InterQual® Criteria does not exist, KePRO will utilize DMAS criteria as specified in the *EPSDT Hearing and Audiology Manual* found under Provider Resources/Manuals on the DMAS website.

Hearing Aids

Web Portal Submission	Fax Submission
Validate specific questions	DMAS 363 Outpatient Services Authorization
on CMN OR upload form	Request
and	Form
attach to request in	
Atrezzo	



Upload Most Recent Audiology Evaluation and attach to reguest in Atrezzo DMAS 352 - Certificate of Medical New (CMN)	Cessity
Provider's Invoice Cost Most Recent Audiology Evaluation	

Provider's Invoice Cost

Complete web based checklist *EPSDT Hearing Aids and Related Devices* and attach to request in Atrezzo

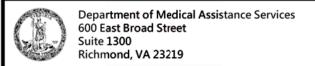
Specific Information for Assistive Technology (Service Type 0092)

Assistive Technology services are available only for Medicaid members under age 21 through EPSDT. AT services are not covered by DMAS for members age 21 and older unless enrolled in specific waivers. Only DME providers (provider type 062) or AT providers (provider type 056 and specialty 016 or 046) may submit AT requests for service authorization. Providers must submit requests when they are aware of the need for AT. There is no retroactive authorization, except in cases where retroactive Medicaid eligibility determination is made. Providers should expect a response from KePRO within 3 business days of receipt. These services are also available as MCO carved out services. Assistive Technology devices are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members.

KePRO will utilize DMAS criteria as outlined in *DMAS' EPSDT Supplement* for AT.

Assistive Technology (AT)

Web Portal Submission	Fax Submission
Complete web based	DMAS 363 Outpatient Services Authorization
checklist <i>EPSDT Assistive</i>	Request
Technology and attach to	Form
request in Atrezzo	



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	Letter of Medical Necessity signed and dated by physician and licensed therapist evaluation; OR
by physician; OR	physician and neoneou shorapist evaluation, or
	licensed therapist evaluation report signed and
licensed therapist	dated by physician
evaluation report signed	
and dated by	
physician. Attach Letter of	
Medical Necessity to	
request in Atrezzo	
Provider's Invoice Cost	Provider's Invoice Cost

Specific Information for Private Duty Nursing (Service Type 0090)

Providers must request services prior to start of care or the request will be approved starting with the date it is received. KePRO will utilize DMAS criteria as specified in the *EPSDT Supplement Nursing Manual* and will provide a response within 5 business days of receiving the initial request. Private Duty Nursing services are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members.

Private Duty Nursing

Web Portal	Fax Submission
Complete web based	DMAS 98 Community Based Care Waiver Request
questionnaire	Form
Upload CMS 485 Physician's	CMS 485 <i>Physician's Orders</i> signed and dated by
Orders signed and dated by	ordering physician OR
ordering physician OR	
	physician order with same data elements as on the
Upload physician order with same data elements as on the CMS 485, signed and dated by ordering physician	CMS 485, signed and dated by ordering physician
Attach to request in Atrezzo	
Upload DMAS 62 EPSDT Medical	DMAS 62 EPSDT Medical Needs Assessment
Needs Assessment and	
attach to in Atrezzo	

If a member is enrolled in waiver that offers PDN and there is a service authorization request for EPSDT private duty nursing, the services will be authorized under the waiver first. If additional hours are needed and they are denied under the waiver, a request may be submitted to KePRO under EPSDT. If a member is receiving EPSDT private duty nursing only, and then is later enrolled in a waiver that offers private duty nursing, then the provider must request an end date for the EPSDT service in order for the member to be enrolled in the waiver and receive private duty nursing.

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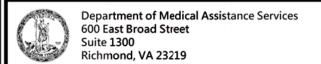
Specific Information for School Based Private Duty Nursing, MCO Carve Out (Service Type 0098)

If a child is in a Managed Care Organization (MCO) and is in need of Private Duty Nursing in the school setting, providers are to request services under Service Type 0098 (EPSDT MCO Carve Out Svcs). Providers must request services prior to start of care or the approval will start on the date it was received. KePRO will utilize DMAS criteria as specified in the EPSDT Supplement Nursing Manual and will provide a response within 5 business days of receiving the initial request. Private Duty Nursing services are covered by DMAS contracted Managed Care Organizations (MCO) for MCO enrolled members except when Private Duty Nursing services are required in the school setting. When nursing is required in the school setting for MCO enrolled members, the services are available as MCO carved out services.

Private Duty Nursing - MCO Carve Out, School Based

Web Portal	Fax Submission
Complete web based	DMAS 98 Community Based Care Waiver Request
questionnaire	Form
Upload CMS 485 Physician's	CMS 485 <i>Physician's Orders</i> signed and dated by
Orders signed and dated by	ordering physician OR
ordering physician OR	
	physician order with same data elements as on the
Upload physician order with same data elements as on the CMS 485,	CMS 485, signed and dated by ordering physician
signed and dated by ordering	
physician	
μ. <i>J</i>	
Attach to request in Atrezzo	
Upload DMAS 62 EPSDT Medical	DMAS 62 EPSDT Medical Needs Assessment
Needs Assessment and	
attach to request in Atrezzo	

If a member is enrolled in waiver that offers PDN and there is a service authorization request for EPSDT private duty nursing, the services will be authorized under the waiver first. If additional hours are needed and they are denied under the waiver, a request may be submitted to KePRO under EPSDT. If a member is receiving EPSDT private duty nursing only, and then is later enrolled in a waiver that offers private duty nursing, then the provider must request an end date for the EPSDT service in order to be enrolled in the waiver and receive private duty nursing.



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Specific Information for Personal Care, and Attendant Care (Service Type 0091)

Providers are to submit requests for service authorization within 10 business days prior to the start of care (SOC), or the approval will start on the date it was received. It is recommended that providers submit their request within 10 business days of the expiration of the existing authorization period if the member continues to need services. If the request is not submitted prior to the expiration of the existing request, the approval will start on the date it was received. KePRO will utilize criteria as specified in the DMAS *EPSDT Supplement B, Personal Care*, and make a final determination within 5 business days of receiving the initial request. These services are available as MCO carved out services.

Personal Care and Attendant Care

Web Portal	Fax Submission
Questionnaire entitled EPSDT- T1019/S5126	DMAS 98 Community Based Care Waiver Request
Questionnaire	Form
	DMAS 7 EPSDT Personal Care Services Functional
	Assessment
	DMAS 7A EPSDT Personal Care Program Agency
	and
	Consumer Directed Plan of Care
	DMAS 99 Community Based Care Recipient
	Assessment
	Form

If a member is enrolled in waiver that offers personal care and/or attendant care, and there is a service authorization request for EPSDT personal care or attendant care, the services will be authorized under the

waiver first. If additional hours are needed, and are denied under the waiver, a request may be submitted to KePRO under EPSDT. If a member is receiving EPSDT personal care or attendant care only, and then is later enrolled in a waiver that offers either of these services, then the provider must request an end date for the EPSDT service in order for the member to be enrolled in the waiver and receive personal and/or attendant care services.

Authorizations that Currently Span Past November 1, 2012

Providers that currently have an approved service from DMAS' EPSDT Unit that is approved past November 1, 2012 need to do nothing. The authorization will be honored and there



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should be no break in the provider's service. Providers must use the service authorization number issued on their approval letter generated from MMIS for submitting claims. If the provider determines that the individual needs a continuance of that approved authorization, the request must be submitted to KePRO prior to the expiration of the initial authorized period. Providers are encouraged to submit the request within 14 business days of the expiration date of the current approved time period. KePRO will receive all authorizations that have been performed by DMAS' EPSDT Unit, both denied and approved, that span past November 1, 2012. If a provider and/or member appeals any decision made by DMAS' EPSDT Unit, DMAS will act upon the appeal through to resolution.

General Information for All Submissions

- KePRO's website has information related to the service authorization processes for all DMAS programs they review. Fax forms, web based service authorization checklists, trainings, and much more are on KePRO's website. Providers may access this information by going to http://dmas.kepro.com.
- KePRO will approve, deny, or pend requests. If there is insufficient medical necessity information to make a final determination, KePRO will pend the request back to the provider requesting additional information. Do not send responses to pends piecemeal since the information will be reviewed and processed upon initial receipt. If the information is not received within the time frame requested by KePRO, the request will automatically be sent to a physician for a final determination. In the absence of clinical information, the request will be submitted to the supervisor for an administrative review and final determination. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instruction on how to file an appeal is included in the MMIS generated letter.
- There are no automatic renewals of service authorizations. Providers must submit requests for continuation of care needs, with supporting documentation, prior to the expiration of the current authorization.
- Personal Care and Attendant Care providers are not to begin providing services until they receive a final determination on their request.
- Providers must verify member eligibility prior to submitting the request. There are



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several mechanisms available for providers to verify member eligibility, located at the end of this memorandum.

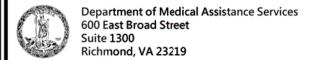
- Authorizations will not be granted for periods of member or provider ineligibility.
- There is no retroactive authorization periods for services identified in this memorandum, with the exception of hearing aid codes identified above.
- Requests will be rejected if required demographic information is absent.

- Providers must use the DMAS forms appropriate for the service(s) being requested.
- Providers should take advantage of KePRO's web based checklists/information sheets for the services(s) being requested. These sheets provide helpful information to enable providers to submit information relevant to the services being requested.
- Providers must submit a service authorization request under the appropriate service type. Service authorization requests cannot be bundled under one service type if the service types are different.

How to Find Out if Procedure Code(s) Require Service Authorization

In order to determine if services need to be prior authorized, providers should go to the DMAS website: http://www.dmas.virginia.gov and look to the right of the page and click o the section that says Procedure Fee Schedule Files. You will now see a page entitled DMAS Procedure Fee Files and CPT Codes. Determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV version opens easily in an Excel spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 - No PA is required 01 -Always needs



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PA

02 - Only needs PA if service limits are exceeded 03 - Always needs PA , with per frequency

To determine whether a service is covered by DMAS, access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.com.

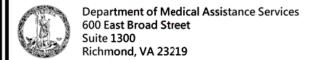
ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below:

Passport Health	SIEMENS Medical	Emdeon
Communications,	Solutions -	
Inc.	Health Services	www.emdeon.com
www.passporthealth.com	Foundation	Telephone:
	Enterprise	
sales@passporthealth.com	Systems/HDX	1 (877) 363-3666
Telephone:	www.hdx.com	
1 (888) 661-5657	Telephone:	
	1 (610) 219-2322	

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on



holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance

1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.